

**STATE OF LOUISIANA**

**AUTHORIZATION FOR RELEASE OF  
CONFIDENTIAL INFORMATION**

**TO BE COMPLETED BY PARENT/LEGAL GUARDIAN**

<b>PART 1: CONTACT INFORMATION</b>		
Student's/Child's Legal Name _____	Date of Birth _____	Social Security # _____
Parent/Legal Guardian _____		Telephone # _____
Mailing Address _____		
<b>PART 2: RECORD REQUEST</b>		
Complete box A <b>OR</b> box B below. Both boxes may not be completed on the same form.		
<b>A.</b> Specify the records to be released for the treatment date(s) listed below in Part 3:  <input type="checkbox"/> COMPLETE RECORD(S) <input type="checkbox"/> Discharge Summary <input type="checkbox"/> History & Physical <input type="checkbox"/> Operative Report <input type="checkbox"/> Consultation <input type="checkbox"/> Progress Notes <input type="checkbox"/> Cardiopulmonary (Indicate EKG, Stress Test, Sleep Study)	<b>B.</b> If initialed below, I specifically authorize release of the following:  Psychotherapy notes and records indicating psychological or psychiatric impairment(s)  _____ Initials of parent/legal guardian	
<input type="checkbox"/> Emergency Room <input type="checkbox"/> Lab <input type="checkbox"/> Pathology <input type="checkbox"/> Radiology Results <input type="checkbox"/> Other _____		
<b>PART 3: AUTHORIZATION</b>		
This does not authorize the release of the following: drug and alcohol use counseling and treatment and HIV/AIDS and sexually transmitted disease testing and treatment.		
<b>I authorize:</b>		
Name: _____ (School System)		
<input type="checkbox"/> <b>TO RELEASE Information TO</b> <b>AND/OR</b> <input type="checkbox"/> <b>TO OBTAIN Information FROM</b> (Place an "X" in the box that indicates if the information is being released AND/OR requested.)		
Name: _____ (Hospital, Physician, Service Agency, School RN and/or other health provider)		
For treatment date(s): _____		
The information is to be released for the purpose(s) of:		
<input type="checkbox"/> Evaluation to determine eligibility or continued eligibility for special education services <input type="checkbox"/> Providing physical therapy treatment <input type="checkbox"/> Providing occupational therapy treatment	<input type="checkbox"/> Designing an individual educational program <input type="checkbox"/> Determining appropriate placement for treatment needs <input type="checkbox"/> _____	
I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the same medical records department receiving this authorization form. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____.		
If I fail to specify an expiration date, event or condition, this authorization will expire in nine (9) months from the date of authorization. An authorization is voluntary. I will not be required to sign an authorization as a condition of receiving treatment services or payment, enrollment, or eligibility for health care services. Information used or disclosed by this authorization may be re-disclosed by the recipient and will no longer be protected under the Health Insurance Portability & Accountability Act of 1996.		
_____ Signature of Student or Legal Representative (Parent/Legal Guardian must sign if student < 18)	_____ Date	_____ (Relationship to student)
_____ Signature of Witness	_____ Date	